DAVID RIDLEY
Senior Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr. Michael Spurr** **Chief Executive** **National Offender Management Service** **Clive House** **70 Petty France** **London** **SW1H 9EX**
1	**CORONER** I am DAVID RIDLEY, Senior Coroner for Wiltshire and Swindon
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 14 May 2015 I commenced an investigation into the death of Calam ATOUR, aged 41. Calam's Inquest was opened on the 1 June 2015 and the final hearing lasted 2 weeks commencing Monday 26 September 2016. As the circumstances of Calam's death pointed to an unnatural death I was required to sit with a Jury. The Jury concluded that Calam died as a result of compression of the neck structures by a ligature and their conclusion and determination as regards the mechanism of death was as follows:- *"Between 9.08am and 11.37am on the 13th May 2015 Calam Atour died in his room at Erlestoke House by hanging himself by a ligature from the window.* *Conclusion - Suicide. Narrative conclusion.* *We have identified 5 circumstances which taken in combination made it probable that Calam Atour's likelyhood of suicide was inadequately addressed.* *1. After the removal of medication on the 22nd April 2015 there was no immediate follow-up to personally explain the situation to Calam and this had an adverse effect on his state of mind. The policy which requires individuals to make their own medical appointments seems inappropriate if a medical intervention has itself caused the issue that makes an appointment necessary.* *2. The ACCT opened on Calam had a significant medical component and it would be reasonable to expect that there should be sufficient medical personnel available to support the review process. This was not forthcoming. Given Calam's preoccupation with*

	his medication it is possible that the lack of medical engagement in the process both exacerbated this preoccupation and lessened its effectiveness. 3. *In reference to the events of the 13th May 2015; the ACCT process appears to be inadequate in identifying when immediate action may be necessary. It is possible that had Calam's threats to take his own life triggered a mandatory response, rather than placing the decision making burden on the subjective opinion of individuals, that increased monitoring might have carried him through to the next assessment that afternoon.* 4. *There is a possibility that the lack of an assurance check at lunchtime on the 13th May 2015 contributed to Calam's death.* 5. *There were staffing shortages and lack of coordination across the support networks for Calam. It is probable that this situation exacerbated the circumstances listed above."*
4	**CIRCUMSTANCES OF THE DEATH** See Box 3 above.
5	**<u>CORONER'S CONCERNS</u>** The **MATTERS OF CONCERN** are as follows:– During the course of the Inquest I heard evidence from a number of Prison Officers who worked at HMP Erlestoke who indicated that at the time of Calam's death that there were staffing issues. At least 3 had left HMP Erlestoke due to the working environment. One specifically referring to stress amongst other factors, another mentioned that she left the prison service because the job was no longer rewarding and I looked to explore my concerns in this area when I came to question [redacted] the current Head of Safe Custody at Erlestoke. She accepted that the situation was quite bad back in May 2015. Even taking into account "overtime payment plus" following the benchmarking that had been undertaken a couple of years earlier, of the 88 that should have been in post the prison was operating with a staff shortfall of just over 15 members of staff. This represented an understaffing of just over 20%. In evidence, I heard that other prisons did not have spare staff capacity, following the "benchmarking" process which was undertaken to achieve efficiencies in the time of austerity. I have been told that there were and are currently significant recruitment problems. On the day of Calam's death [redacted] for the large part of the morning was the only Officer present on the Alfred Unit. As a consequence of her being busy she did not have a chance to look at a recent entry in an ACCT document for Calam, which she said, had she seen the full entry would have prompted her to speak further with Calam so as to ensure his welfare. It is unclear as to whether or not the outcome would have been different had she done that. In further questioning [redacted] I asked about the position today as many of the Officers I spoke to who were still at Erlestoke said that the situation was now a lot better, which was encouraging to hear. I was, however, alarmed to hear that actually the only reason it is better is mainly due to the fact that 2 of the units were closed following an outbreak of violence during the Summer of this year which resulted in considerable damage being caused to both Alfred and Wessex Units by prisoners that has meant that they have had to be closed so that refurbishment/repairs can be carried out. That is the main reason that there has been an improvement and I was told that the scheduled re-opening of Alfred & Wessex was to be at some point in 2017. Erlestoke is currently running with 13 vacancies unfilled which can be accommodated on the basis of the closed units. I am concerned by this situation. I am aware from [redacted] that potentially a fresh round of benchmarking is to be undertaken in the near future as there are concerns nationally in relation to the number of prison deaths having risen in recent years. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances my statutory duty is to report those concerns to you. The matter of concerns are as follows:-

	I. I am concerned that unless the staffing number issue is resolved that when Alfred & Wessex Units reopen next year it will again create a significant staffing issues and a reduction of around 20% in operational personnel. I am concerned that this level of reduction has the potential and propensity to create an unsafe system of work for the prison officers (I heard during the course of the Inquest that 1 officer who was due to attend Court to give evidence sadly was the victim of a serious assault whilst on duty at Erlestoke recently). I am concerned that with a reduction in operational staff members that there is a risk that such assaults will increase. Such assaults can result in serious injury or even worse death. I am also concerned as regards the welfare of the prisoners and as regards the ability of the prison officers as a result of the pressure on their numbers to safeguard the lives of those in prison insofar as reasonable practicable against the risk of prisoners harming themselves or others or even taking their own lives. It was clear that there was a huge amount of reliance of goodwill amongst prison staff but with the continuing pressure on staffing the reality I heard is that the goodwill gets eroded overtime, as the ability to function in the workplace becomes increasingly pressurised and more stressful. The position is not sustainable long term. II. I fully appreciate that this issue overlaps with matters of Government policy in a time of austerity but I have made this report out of a genuine concern for both the prison officers and the prisoners at HMP Erlestoke and I am of the view that if I do not air these concerns, that I would be discharging my statutory duty as a Senior Coroner having heard the evidence. III. It was also brought to my attention that in terms of benchmarking on the previous occasion, that it did not take into account the type of prisoners that may be sent to a particular prison. Insofar as Erlestoke is concerned, due to its rehabilitation categorisation and as regards the training and courses made available to prisoners that a considerable number of the prisoners at Erlestoke are either “lifers” or on an indeterminate prison sentence, both of these, of course, relate to serious crimes. I am concerned that not taking into account the type of prisoner when determining safe/efficient numbers of personnel could lead to a lower than safe number of personnel available for duty. This concerns overlaps and dovetails with my concern at para I. above.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action to address the concern highlighted above.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 7 December 2016. I, the Senior Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Governor at HMP Erlestoke Family of Calam Atour via their Lawyers, Tuckers Solicitors I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9	Dated 12 October 2016 Signature_____ HM Senior Coroner for Wiltshire and Swindon

Copy to:
1. RadcliffeLeBrasseur
   Solicitors representing Doctors at the Adcroft Surgery
2. Government Legal Dept.
3. [redacted] Avon and Wiltshire Mental Health Partnership NHS Trust